Residential Care Home (RCH) Industry Statement
AHONN & RCHCAN

As front line providers of assisted senior care we are very much aware of the overall rapid decline in all long term care beds for the chronically ill who have a need for heavier, 24hr, custodial care, and supervision both in the Community & in Skilled Nursing Facilities (SNF's) in Nevada. We would like to share with you our and the communities' growing concerns and issues facing our residents, many of them with dementia, who have progressive custodial care needs and are in dire need of these long term care beds.

- **The only viable 24hr, custodial care and supervision options are SNF's or RCH's. How do they fit in the long term care continuum?**
- **Major legislative/Systemic changes that have occurred in the last 3-5 years that are contributing to the rapid decline in community based Residential Care Home beds.**
- **Need to Clarify/ increase rules and regulation in NRS for SLA type entities (NRS 435/433 and the SLA in all settings including mental and developmentally disabled, SNAMH, Desert regional).**
- **Consistent, Fair and Balance for Use of State Funds and regulations.**
- **Increase funding to the BHCQC to enable them to improve monitoring & supervision**.

VIABLE CARE OPTIONS THAT PROVIDE 24HR CARE & SUPERVISION; SNF's & RCH's .

Skilled Nursing Facilities - See *the LTC Comparison table hand out* for a concise description of facts- which we describe in more detail below.

There are currently 5000 Skilled Nursing Facility (SNF) or Nursing Home beds in Nevada. In the past, most of these beds were designated to long term, chronic, custodial care patients requiring 24 hr. supervision including those with varied levels of cognitive loss and multiple medical problems. Nursing homes are reimbursed from Medicaid at a rate of $200/day for these patients.

Now, at least half (2500) of the 5000 existing SNF beds are being reallocated to acute short term rehab which is reimbursed by federally funded **Medicare** at **$600/day** and to the newly approved Behavioral Rate for those who have severe behavior and mental illness issues which is reimbursed at **$300-$500/day** by state **Medicaid** funds. This is a huge financial benefit and incentive to the SNF to continue to take the higher reimbursements for Short Term Rehab and Behavioral Rate cases of **$600 & $500/**day and decline admissions for long term, chronic, custodial care cases which are only reimbursed from **Medicaid at $200/day**. This is an incentive for Hospitals and Insurance companies as well. For example, if a Hospital/insurance company can move a hospital patient to a SNF at $600/day to finish the treatment they save more money than if that same patient was to continue treatment in the hospital getting treatment on the same DRG payment. This trend is likely to grow.

Even with the plans to build more nursing beds, these beds will be held for Short term Rehab cases. Indeed, these facilities are often designated *only for* short term rehab and have no long term care beds. There is a free flowing supply of Medicare patients with acute illnesses and

problems who need to be discharged from the hospital and continue treatment in short term rehab. These patients are healthy enough to be discharged back into the community. These patients are far different from seniors who have chronic long standing health problems and need long term custodial care. There is talk of plans to use the new behavioral rate beds in SNF's for people with Alzheimer's who have severe behavioral problems, but the 100 or so beds allocated for this use are unlikely to fill the void of 2500 SNF chronic care beds that are being reallocated to short term rehab and actually were created for difficult mental illness case more than dementia cases. Thus, the problem of finding cost effective, community based long term care beds for those with mild to moderate dementia or chronic care needs is likely to increase. What will happen to older chronically ill patients who are not likely to improve after rehab? Where will our most frail and needy Nevadans go to receive the 24hr custodial care and supervision they require? These needs cannot practically be met with the expensive, incomplete care options provided in In Home Care, Adult Day Care or Assisted Living.

Licensed & monitored Residential Care Homes are the only practical, safe and cost effective care option for those requiring 24 hr. care & supervision. They offer both private pay Nevadans and state Medicaid a great value and cost savings. This is a resource that needs to be supported financially and through legislation and regulation.

Residential Care Homes

There are currently 3000 Residential Care Homes (RCH'S) in Nevada. These resident types generally include seniors and people with a varying degrees of Dementia /Mental Illness, in combination with chronic disabilities.

RCH's are currently the only practical and cost effective, *largely financially self- sustaining,* community based alternative to a Nursing Home if someone has a need for 24 hr., supervised, long term, and custodial care. A significant fact that is often overlooked is that the majority of RCH's (90%) are utilized by low to middle income disabled seniors who are private pay & pay for services out of their own pocket. The RCH industry has been a financially self-sustaining industry with only a small portion receiving funding from Medicaid through waivers. The residents & families who reside in Residential Care Homes (RCH's) choose to live in these safe, cost effective, family centered, community based RCH's as opposed to being institutionalized in a Nursing Home (SNF) and then be quickly forced onto state Medicaid because the high private pay costs of nursing homes are out of reach for those private pay residents in a low cost RCH. It is important to note that the RCH owner agrees to provide all the care and services at rates of $1,000-$2,000/mo. and the low to middle income family choose to pay that instead of being institutionalized in a SNF. RCH'S are cost effective not only for the private pay resident's but also for the state. RCH's are the answer to the endless requests of all major agencies for more cost effective, community based, long term care options.

When compared to all other states, RCH's in Nevada are the best in the nation. As one can see by looking at The State to State Comparison Table *(See attachment),* only Nevada's RCH's have annual state surveys which are publically posted on line for transparency, a BELTCA certified

administrator, sprinklers, and liability insurance. California and other neighboring states lag behind in theses protective supervision measures for their RCH"S. This is something the state could use to get grants for other RCH related pilot projects.

MAJOR LEGISLATIVE/SYSTEMIC CHANGES CAUSING UNCERTAINTY IN THE RCH INDUSTRY.

Over the last 3-5 years state regulators & legislators have passed a progressive series of changes that have created uncertainty in the RCH Industry, specifically in RFFG of 10 or less that has stifled growth & expectations for an entire industry and related care providers.

The changes are related to:

- **The repeal of NRS 278.02386,**
- **Changes in interpretation of laws now requiring RCH's to have institutional/commercial sprinklers instead of the residential 13 R sprinklers that have been required for the last 17 years.**
- **Current state labor laws that are not in line with the federal standards.**

This uncertainty has stopped the growth of this once financially stable model of care at a time when more community based long term, chronic, custodial care beds are in high demand. The uncertainty is also causing potential new providers to rethink the investment of their time and money in this industry. In addition, current business values are falling, and the existing providers are looking to get out.

We ask this panel take a close look at how these changes are negatively affecting Nevadans ability to choose cost effective, community based long term care beds. We ask for your support to help save our industry and the entire state health care system.

The following are ways you could support the improvement & regrowth of our industry and quell the uncertainty so we can continue to provide safe, cost effective, quality care to the resident's we serve and help protect the rights of Nevada's seniors and disabled.

Reinstate NRS 278.02386, sections 1 & 2. NRS 278 was a state law for many years & mirrored the Federal Fair Housing laws that protect a senior or disabled person's right to live in the same residential communities as the non-disabled. Section 1, required all communities to define a single family home to include a RFFG of 10 or less. Section 2, required a single family home used as a RFFG, be defined as residential for all building and zoning purposes. Section 3, related to a minimum distance separations between RFFG homes and was found by Nevada Fair Housing to be discriminatory. We believe it was this section only which was found unconstitutional that was intended to be removed. (see attached NRS 278.02386 that was repealed)

Without the protections set forth in sections 1 & 2, we and the resident's we serve, risk exploitation and discrimination on all levels of building and operation. While we will prevail at the federal level, we believe the state should be supportive on this issue and protect the rights of seniors and the disabled to remain in the communities they have lived in their entire lives and not be forced to be institutionalized.

Write new law that protects a senior or disabled person's right to safely remain in the community in a fully alarmed & monitored RCH with 13R sprinkler.

Over the last few years the new fire Marshal, without notice or small business impact study, has changed his interpretation of fire and life safety codes from that of all previous Fire Marshalls who have served Nevada over the last 17 years**.** RFFG of 10 or less have been required for the last 17 years to have 13R residential sprinklers in their homes and since that time there have be **NO** documented fire related deaths or injuries in these sprinkled RCH's. This proves that the 13R residential sprinkler provides adequate fire safety for the residents who reside there. Many states do not require any sprinklers at all in their RCH's. Nevada was one of the first states to require a 13 R sprinkler 17 yrs. ago. We have asked the fire Marshall's office how his interpretation of the same national fire and building codes used in all other states use can vary so widely from previous Fire Marshalls not only in Nevada, but in many other states as well. The RCH industry fully supports the safety and protection of its residents for fire safety, but we believe the new changes implemented by the newest Fire Marshall to require a, I-2, institutional /commercial sprinkler system, for more than 5 Category 2 residents, is excessive and in most cases is not even physically possible to do in residential homes due to the nature of a residential structure which is not designed to accommodate a huge institutional type system, due to weight of system, availability of water pressure etc. The HCQC, the Fire Marshall and the RCH industry have worked together and have implemented a "temporary administrative fix". At one stake holders meeting a representative of the fire marshal's office stated they were concerned about the bottom 5 % of RCH's. We are not sure what exactly he meant by that statement but believe that the bottom % 5 are included in the 100 % state wide safety record our industry has built in the last decade and a half. We understand that as in all industries there is a range of providers and cost points for care, but compared to RCH in all other states, RCH in Nevada are among the best and until recently were largely financially self-sufficient and privately funded.

The HCQC is responsible for monitoring how all RCH's are operating and if they are following the rules and regulations. In fact, there is currently a 3D rule which states that a RCH can be closed if they receive 3 D's on surveys. If any RCH is not in compliance the state has the ability to fine and inspect homes as they see fit. Focus on the low quality care providers is a good way to improve overall care if that is the goal. Our industry continues to reach out to legislators including ADSD and HCQC to help to continue to improve the quality of care

Please help us to protect the rights of seniors, the disabled and their families to choose how much "safety" they feel is needed to balance safety with quality of life. Help us scribe a new NRS that states RFFG of 10 or less shall be required to have a 13 R sprinkler which is consistent with the type of building structure, in addition to the other current fire and safety measures we have safely utilized for the last 17 years. This issue must be clarified in NRS or we and our industry and its residents will be subject to continued arbitrary actions by the Fire Marshall.

Urge legislators pass a state labor law that mirrors the Federal Labor Law CFR 552.102. We lobbied heavily for this last session in SB 146, brought forth by David Parks and Irene Bustamante. (see links below items submitted for comment to the joint finance and ways and means budget

committee, Assembly Labor and commerce Committee) Unfortunately, the part of SB146 that was not approved, despite overwhelming approval in the Assembly and Budget Committees was the live-in exemption. The live-in exemption mirrors the federal law and is a benefit for both the employee and the employer. The exemption allows workers to live in a facility and still be paid for every hour worked. They benefit by not having to pay for housing, utilities, and transportation to and from work and having a sense of family. This is clearly something the employee can choose if it is the right fit for them. The employer benefits by not being required to pay for overtime hours and or sleep time. The employer and employee sign a mutual agreement that satisfies both parties. Small RCH's of 10 or less have relied on live-in workers for years. This exemption is a significant reason why RCH's are able to operate and provide 24 hr. care at such a low cost to the residents. In addition, having live-in workers promotes "patient centered care" which is a new buzz word that RCH's have been utilizing and providing for years. Being able to have small consistent staff who knows each resident is the best outcome for the residents, many of whom have varying degrees dementia, mental illness and other chronic disease and may otherwise have difficulty adjusting to frequently changing caregivers.

Unfortunately, the new enforcement of Nevada state labor law requires every worker, to be paid at overtime rates for sleeping and just being on the premise even when they are not actually working. This forces employers to have to more shifts and workers in order to avoid having to pay overtime or sleep hours. It also decreases continuity and patient centered care by increasing the revolving door of workers causing seniors and the disabled more difficulty getting the care they need when staff is changing.

The absence of this live-in exemption affects small RCH's, as well as, PCA, and home attendant companies and the consumers of these services. If a family pays for PCA services at $25/hr. and they are required to be paid for sleep and overtime (24 hrs @ $25 / hr) is $600/day or $18,000 per month. In addition, if 24 hr care is needed it will likely be with 3 separate 8hr shifts which decrease continuity. Similarly, RCH's will have to increase their rates to accommodate for the mandatory overtime and sleep hours even if the employee is not working.

Needless to say many low and middle income families can't pay these higher rates and will inevitably have no choice but to become a financial burden to the state Medicaid fund. The live-in exemption benefits everyone involved, the employee who chooses this type of position, the employer, and the consumer who continues to be able to afford good quality, low cost, 24hr care and supervision. Moreover it is the current federal labor law.

CLARIFY/INCREASE THE RULES AND REGULATIONS IN NRS 435 & 433 FOR SUPPORTED LIVING ARRANGEMENT'S (SLA'S)

RCH industry has recently become aware of an apparent competing industry for long term care / post-acute care services.

While some divisions of SLA's, like that of the developmentally challenged, appear to be well developed and monitored others like that in SNAMH and Desert Regional are less transparent. There is a growing concern over other SLA's entities governed under NRS 435 & 433 which are not

well defined. We have recently come across many large companies that fall under SLA, who advertise on their websites that they provide similar assisted care services as RCH's which fall under RFFG governed by NRS 449. *(See sample web site to illustrate the range of services offered in SLA.)*

This is causing a lot of confusion for consumers in the community and in the health care industry in general, for providers who utilize and provide assisted care services, PCA companies, social workers, discharge planners, guardians, etc.

At a recent Alzheimer's task force meeting it was reported that entities that fall under SLA's (NRS 435 / 433) are not licensed, they are only certified and are over seen by the large private companies.

There appear to be three types of SLA's developmentally disabled, SNAMH, and Desert Regional. All of these entities function separately and seem to have no overlap. In fact, it is odd that each SLA type do not know what the others do or how they are different.

At the Alzheimer's task force meeting they had a speaker from ADSD Developmentally disabled SLA as the speaker but in fact the overlap of older adults with mental , cognitive and chronic care needs is more in the SNAMH and Desert Regional SLA types. We need help to find out what each does and what criteria and definition are for the specific resident types / allowable conditions and functional status in each of the three SLA independent / transitional settings are.

There are several issues of concern that need clarification: Why are there two competing sets of regulations and protections for similar types of care in NRS 449 for RFFG and NRS 435/433 for SLA facilities?

What are the regulations for protective supervision and safety for the disabled in each SLA setting? What is the expected time frame one can be enrolled in an independent/ or transitional living setting? 1 year? 2 years? Are there different regulations for each SLA type? Is it realistic to believe an older person with many chronic illnesses will transition out of SLA to independent status? Might that misclassification result in a more chronically disabled person getting less care, supervision, and safety than if they received care in an NRS 449 setting?

There have been reports that SLA's have contracts with prisons to house released offenders. How are these types of homes monitored when these resident types are released in to residential communities? Are these released prisoners released into the general disabled SLA population in a less supervised SLA home? Who tracks these releases and is there any public disclosure or transparency available to the community at large? Recently homeless people have been placed in SLA homes and again we wonder about transparency for the residential communities and if homeless and released prisoners are protected classes under fair housing laws for this use of a residential home. Might this be a reason for the lack of disclosure for individual SLA facility locations to the public?

RFFG, NRS 449, on the other hand, have clear definitions as to the allowable and non-allowable types of residents, functional status etc. All entities under RFFG including Assisted Livings, RCH's, SNF's, half way houses and homes for drug and alcohol rehab are listed for public viewing on the HCQC website, SLA's have no public listings of any kind that we have found and when you call Desert Regional or any SLA regulator they say that is private information and they only release the location of the corporate office. All entities that fall under RFFG's, NRS 449 are monitored and supervised by DHHS under the HCQC and receive unannounced visits from the State Ombudsman. All surveys and complaints are publically available on line which demonstrates a high level of transparency. Neither the HCQC nor the State Ombudsman have any jurisdiction over SLA's. The HCQC reports frequent complaints from residential communities about "unlicensed group homes" only to find out they are not group homes at all, but are really certified SLA homes. The only course of action is to report the complaint to Desert Regional. We have found it is very difficult to get any information on the investigation and resolution process from Desert Regional about these community complaints. Thus, the community remains upset that their complaint about what they think is an "unlicensed group home" is unanswered. SLA's care for active, more independent residents who have the ability to walk the streets of a community unsupervised. Many people in SLAs with mental illness are heavy smokers and may have behavior issues. It would be beneficial for a community to have knowledge about where these homes are in their communities and be able to communicate with the staff and management of the facility to discuss observations they have seen with these residents while they are roaming in the community in order to ensure safety for the residents and community alike.

These are issues that need clarification and need to be defined in NRS in order to ensure recipients in all settings are receiving adequate protective supervision based on their physical, cognitive and functional care needs.

We urge legislators to write a new statute that clearly defines the criteria for all SLA allowable & non allowable resident types. SLA types need more definition, structure, and transparency.

FAIR AND JUST BALANCE FOR USE OF STATE FUNDS

A fair and relative value payment system needs to be created to provide balanced & consistent payments to providers for the services rendered. Especially for those who receive reimbursement from state and federal funding. In the past, SLA's have been investigated and found guilty of overbilling and milking the state budget. The state was reportedly paying SLA's with mental illness residents up to $6,000/mo. per resident compared to only $1,000/mo. for a mental illness resident in a RCH with mental illness endorsement offering similar services of housing, caregiving and medication management.

While we have recently heard that reimbursement rates for SLA's who provide transitional living services have decreased but they still far exceed those for RCH's with mental illness or dementia endorsement waivers. Why do RCH's with Dementia Endorsement, who are **the only group** that have a required **mandatory** staffing ratio of **1 caregiver to 6 residents with a required awake**

night time caregiver receive far less funding than that SLA's who provide care to clients who are in an independent/transitional program who likely need less care and supervision.

We believe there are many older adults with chronic mental health and cognitive issues in addition to chronic medical conditions in the SLA system that are receiving additional state funds beyond the monthly SLA reimbursement for PST (psychologic skills training) & BST (basic skills training) who are clearly not benefiting. These services are billed to Medicaid at $38/hr compared to in-home custodial care through a licensed PCA company at $17/ hr. We wonder if this is an inefficient use of state funds.

We ask why is a SNF, which has an enormous overhead, being paid only $200/day or $6,000/ mo. for heavy custodial care patients while SLA's have been reported being paid the same $6,000/ mo. for people who function at a higher level and are in transitional program with the goal of becoming independent. It would seem these higher functioning SLA residents would need less financial resources than the high, custodial care needs of SNF patients. This apparent inefficient use of state funds needs to be reevaluated.

The large gap in reimbursement between SLA's and RFFG is very concerning. Not only does it appear discriminatory against seniors and the disabled, it does not make fiscal sense that a younger, relatively healthy person who is perceived to have the capability to "transition" to independent living should be reimbursed at a higher rate than a chronic care resident who are usually advanced in age and are afflicted with Dementia, Mental illness and Chronic Illness and need more assisted care and supervision.

We urge other groups like the Alzheimer's task force, other long term care committees and state budget committee to speak up and act to establish fair and balanced reimbursements system based on the cost of care and services required.

Clearly Defining group types

While we applaud the efforts of the Strategic planning committee to find practical, cost effective ways to provide quality care, we believe it is unrealistic to combine all people into one group for the purpose of state waivers. There are clearly at least two categories of people who use state waivers. Lumping them together does each group a big disservice

One group consists of those who are younger, more mobile, with varied levels of developmental or other life challenges who, with some amount of training and assistance may be able to obtain and maintain a job. The other group consists of older adults with a many health issues who will not "get better" and will continue to need more assistance with personal care needs and actives of daily living as their their mental, cognitive or physical disabilities get worse.

In Sum, each individual has a unique set of circumstances and care needs and both groups need to be represented fairly. We need more specific definitions of what the allowable & non allowable resident types are in SLA's. We need to develop a set of criteria for people to be eligible for independent living / transitional living. We must do so to prevent the many who are miss

classified as candidates for transitional living from being placed in a far less safe setting or facility than those who are protected in RFFG under NRS 449.

INCREASE FUNDING TO THE HCQC TO ENABLE THEM TO IMPROVE MONITORING & SUPERVISION

We have heard many reports that the HCQC has struggled over the last years with low staffing and high turnover of high quality staff due to low pay and other administrative pressures. The RCH industry supports the great work of the HCQC staff and would like them to be able to provide more oversight and monitoring to crack down on low quality providers who shine a bad light on the great care and service that most RCH's provide. We hope you support the BHCQC and their staff to ensure they have the tools they need to keep Nevada's RCH industry among the best in the nation.

As industry representatives, RCHCAN and AHONN request to be added to agenda on the state health care planning meetings to be the unheard voice of the RCH industry. Given the size and relevance of our industry to the overall health care system we can provide valuable insight and information which seems to be missing in the discussions. We continue to be available to work with all of our partners in the long term care system.

Shawn McGivney, MD, RFA - President of RCHCAN Jose Castillo, - President Ahonn

Enclosures.
-LTC Comparison Table
-State by State RFFG Comparison Table
-NRS 278.02386 Sections 1 & 2.
-SLA provider with a wide range of offerings.

Old material referenced in past meetings.
Alzheimer's task force meetings comments 8/21 and 10/23
see comments on the right side of page.
http://adsd.nv.gov/Boards/TaskForceAlz/Agendas/

Assembly committee on commerce and labor. 5/8/15
https://www.leg.state.nv.us/Session/78th2015/Minutes/Assembly/CL/Final/1148.pdf
see testimony and linked exhibits.
Pg 8 -16, and click exhibit links., Pg 12 Shawn McGivney

5/15/15 Joint meeting of the senate committee on finance and ways and means
Jose Castillo public comment.
https://www.leg.state.nv.us/App/NELIS/REL/78th2015/Meeting/3905?p=3000000&p=6016058

Shawn McGivney- public comment
https://www.leg.state.nv.us/App/NELIS/REL/78th2015/Meeting/3905?p=3000000&p=6016059